EMERGENCY ACTION HEALTH CARE PLAN (Part 1)

(TO BE COMPLETED BY PARENT)

Student's Photo

Student Name_____ _DOB_____ School_____

Allergies_____Grade_____

Parent/Guardian_____ Phone (H)_____Phone (W)_____Phone(Cell)_____

Address_____City_____Zip_____

Emergency contact _____ Relationship_____ Phone_____

Emergency contact _____ Relationship_____ Phone_____

Name of physician_____ Office phone number _____

TO BE COMPLETED BY THE PHYSICIAN:
DIAGNOSIS: _____
POSSIBLE SYMPTOMS_____

EMERGENCY ACTION IS NECESSARY IF THE STUDENT HAS THE FOLLOWING SYMPTOMS!!!

_____
_____
_____
_____

A. Steps to take as emergency support:
   1. _____
   2. _____
   3. _____
   4. _____

B. May return to classroom if_____
C. Contact parent/guardian if_____

DAILY MANAGEMENT PLAN:

1. Identify areas which may aggravate the disorder (exercise, foods, etc):

   _____ _____ _____

2. Special Procedures_____

   _____ Educational concerns_____

   _____ Physical Education concerns_____

   _____ Sports Precautions concerns_____

   _____ Recess Precautions_____

   _____ Special Considerations on Field Trips_____

   _____ Other _____
   _____

Physician and Parent Signature Required. Please turn to the other side to complete and sign. Thank You! →→

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LYNCHBURG CITY SCHOOLS

EMERGENCY ACTION HEALTH CARE PLAN (Part 2)

Dear Parent or Guardian:

The Lynchburg City Schools attempts to discourage administration of medication during school hours, and request whenever possible medication doses be scheduled other than school hours. Recognizing that this is not always possible, we will cooperate in giving medication that must be given during school time. Our regulations include:

1. Written orders using this form from a physician, detailing the name of the medication, dosage, route, and time interval of medication to be taken and plan of care.
2. Using this form, the signature of the parent or guardian requesting that the school district comply with the physician's order and plan of care
3. Medication must be brought to school by the parent or guardian in a container appropriately labeled by the pharmacy.

MEDICATION(S)

Medication	Dose	Diagnosis	Time Med to be Given	Route	Side Effects
1.					
2.					
3.					
4.					

I have prescribed the medication(s) listed above and reviewed the Emergency Action Health Care Plan for this student. The plan is in accordance with the student's medical management.

☐ **Current School Year (please check and fill in current school year) 20_____ to 20_____**

_____ _____

Physicians Signature Date

PARENTAL CONSENT

I give my permission for school personnel to follow the Emergency Action Health Care Plan and administer the prescribed medications in accordance with the above instructions. I understand that I am responsible for providing the school with the prescribed medication needed by my child. I acknowledge that I have read, understand, and do now support the Emergency Action Health Care Plan as outlined on part 1 and part 2 of this form. I agree to allow information on this Emergency Action Health Care Plan to be shared with the adults responsible for my child's care. I hereby release the Lynchburg City School Board, its employee and agents from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I am aware that should I move to another attendance zone with Lynchburg City, I will need to work with the new school to continue with the above health care plan for my child.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Nurse/Health Assistant Date

A new Emergency Action Health Care Plan is required on an annual basis and a revision with any significant change in the student's health status
Lynchburg City Schools Emergency Action Health Care Plan: Emergency Action Health Care Plan

Revised 06/26/13